Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RAYMOND GLASS DC
3100 TIMMONS LANE #250
HOUSTON TX 77027

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Number 19

MFDR Tracking Number
M4-13-0152-01

MFDR Date Received
September 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…In my review of this claim, I find that it was not reimbursed per the Commissioners Bulletin #B-0044-11…"

Amount in Dispute: $33.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 29, 2012	97750-FC	$33.28	$33.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets forth the medical fee guideline for specific services.
3. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - W1 – workers compensation state fee schedule adjustment

Issues

1. Did the requestor receive appropriate reimbursement for a Functional Capacity Evaluation (FCE)? Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. The submitted documentation is reviewed. Start time 9:00am and end time 1:00pm for a total of 4 hours reported (16 units).

   An FCE is reimbursed in accordance with 28 Texas Administrative Code §134.203(c) which states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…(2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Also, 28 Texas Administrative Code §134.203 (h) states in pertinent part, "When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount or (2) health care provider's usual and customary charge…"

   Reimbursement is calculated as follows:

   Division conversion factor of $54.86 divided by Medicare conversion factor of $34.0376 x participating amount of $32.58 = $52.51 x 16 units = $840.17; however, the requestor's usual and customary charge of $839.20 is less. Therefore, the total allowable is $839.20. The insurance carrier paid $805.92. Based upon the documentation submitted and the requestor's table of disputed services, additional reimbursement in the amount of $33.28 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $33.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $33.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.